

me on anything. My time is coming and that will be the end. I'm ready for it and you and the doctors have to be ready for it too."

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Informed patient consent was received.

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The generic-patent medicine conflict flares up again in The Netherlands

Recently I reported in this journal¹ how it became necessary for a judge to settle a dispute between the pharmaceutical industry and certain Dutch pharmacists. It considered the question of whether a pharmacist is permitted, without prior consultation, to give a patient a (cheaper) generic drug instead of the patent drug mentioned on the prescription.

Another dispute has now arisen after the pharmaceutical industry discovered that healthcare insurers were paying general practitioners (GPs) a bonus if they prescribed generic drugs, such as simvastatin (which reduces cholesterol content) or omeprazole (which reduces the production of gastric acid), instead of the more expensive patent forms (Zocor and Losec, respectively). According to the national newspaper, *Trouw*,^{2,3} Menzis, one of the largest healthcare insurers, offered each of 2300 GPs up to €8000 annually if they switched their patients from patent drugs to the equivalent generic forms. Since the offer was made, more than 160 GPs have agreed to comply with this condition. If most GPs follow this example, Menzis hopes to save more than €3 million each year. GP Geert van Loenen and five other doctors,⁴ however, have rejected the offer and are annoyed that their colleagues "have sold themselves in such a way to the insurer". At the same time four of the leading drug companies; Pfizer, Merck, AstraZeneca and Altana, have taken legal action against Menzis. One of their main arguments was that there existed a code which stated that insurers were not permitted to influence the medical profession on how to treat their patients. On 14 October 2005,⁵ a judge at the law court in Arnhem decided otherwise. He concluded that the competition that exists between insurers since a recent law on health insurance was approved by the Dutch parliament has changed the system. It is in the interest of the insurers to offer their patients the lowest insurance rates. This may entail the payment of a bonus to the GP as long as the patient is not the worse for it. The GP has the right to determine what drug he wishes to prescribe. Furthermore, the code (mentioned above) was not devised for the purpose of protecting the pharmaceutical industry.

According to the newspapers, the Royal Dutch Society of Medicine is surprised at the judicial outcome and a number of patient

organisations are disturbed by the judge's decision. The pharmaceutical companies are now considering whether they should take the issue to a court of appeal.

In my opinion, there exists here a difference between a legal and an ethical solution to the conflict. I believe that it is unethical for a physician to accept a bonus from an insurer. I hereby express my admiration for those GPs who have declined to sign the contract with the insurer, Menzis.

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Consent for anaesthesia in cataract surgery

Cataract surgery has evolved rapidly over the last decade. Previously such cases required admission for prolonged postoperative convalescence. However, currently such procedures are carried out as day cases. An area where significant change has evolved is the role of anaesthesia in cataract surgery.

Recently, a growing number of surgeons have been performing cataract surgery using topical drops to achieve anaesthesia. However, case selection and operator experience impose a limit on the use of topical anaesthesia.¹ Other local techniques for delivering anaesthesia include sub-Tenons and peribulbar block, although a minority of patients might require sedation or even general anaesthesia to achieve anaesthesia.

The consent of such patients is an area of concern. While complications such as retrobulbar haemorrhage, globe perforation, muscle injury, and brainstem anaesthesia occur only rarely, nonetheless the outcome might have serious implications with regard to the visual outcome, or could even be death. In some cases where sedation is necessary during the procedure, formal consent might not have been obtained. Furthermore, appropriate advice—for example, fasting in cases of planned local block—would not, in such circumstances, have been given to the patient.

A survey of 23 ophthalmic surgeons (all grades) who routinely perform cataract surgery (West London ophthalmic units) revealed that up to 80% of surgeons do not obtain formal consent for local anaesthetic procedures and a further 86% do not discuss the options of local anaesthesia with patients. However, about half of the surgeons do mention the option of general anaesthesia during the outpatient visit.

The high number of surgeons failing to obtain consent is despite the recommendations of the Royal College of Ophthalmologists (RCO), which state that surgical assessment should also include discussion of the type of local anaesthetic for each individual patient.²

Currently, it is usual for a tick box system on the consent form to indicate the type of anaesthesia (without indicating the type of local technique) the patient is to receive, with an informal consent being taken verbally by the anaesthetist or the surgeon administering the block.

According to the guidelines of the Royal Colleges of Anaesthetists and Ophthalmologists³ a separate consent sheet is not necessary for the anaesthetic part of the procedure.

However, a separate consent form and a standard method for discussing the options of anaesthesia in the outpatient clinic could avoid unnecessary litigation and ensure that all the appropriate options had been offered to patients in good time before having cataract surgery.

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BOOK REVIEWS

The Trust Prescription for Healthcare: Building Your Reputation with Consumers

Edited by D A Shore. Health Administration Press, 2005, \$63.00, pp 165. ISBN 1567932401

Taking a phrase from President Clinton's successful presidential campaign in 1992, this book could have just as easily been called *It's About Trust, Stupid*. In his book, David A Shore, PhD, associate dean and founding director of the Trust Initiative at the Harvard School of Public Health, presents